



Colorectal Screening Form

Last Name		First Name		Middle Initial	Birth Date MM / DD / YYYY	Admin Site #
Social Security Number - -		Phone Number		State ID		
Date initial test scheduled or fecal kit distributed Date <u>MM / DD / YYYY</u>				Screening adherence <input type="checkbox"/> Test done <input type="checkbox"/> Not done, FOBT/FIT kit not returned <input type="checkbox"/> Not done, appointment not kept.		
Take home FOBT/FIT Date <u>MM / DD / YYYY</u> Indication for test <input type="checkbox"/> Screening Result <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown Outcome <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete/Inadequate				Provider specialty <input type="checkbox"/> General Practitioner <input type="checkbox"/> Internist <input type="checkbox"/> Family Practitioner <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> General Surgeon <input type="checkbox"/> Radiologist <input type="checkbox"/> Colorectal Surgeon <input type="checkbox"/> Physician Assistant <input type="checkbox"/> OB/Gyn <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Licensed Practical Nurse <input type="checkbox"/> Nurse Practitioner Next test recommended in this cycle <input type="checkbox"/> Colonoscopy <input type="checkbox"/> None, cycle complete		
Colonoscopy Date <u>MM / DD / YYYY</u> Indication for test <input type="checkbox"/> Screening <input type="checkbox"/> Surveillance <input type="checkbox"/> Diagnostic Result <input type="checkbox"/> Normal/negative/diverticulitis/hemorrhoids <input type="checkbox"/> Other findings, not suggestive of cancer/polyps <input type="checkbox"/> Polyps/suspicious for cancer/presumed cancer <input type="checkbox"/> Inadequate/Incomplete test with no findings Outcome <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete/Inadequate Was the cecum reached during this colonoscopy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				Provider specialty <input type="checkbox"/> General Practitioner <input type="checkbox"/> Internist <input type="checkbox"/> Family Practitioner <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> General Surgeon <input type="checkbox"/> Radiologist <input type="checkbox"/> Colorectal Surgeon <input type="checkbox"/> Physician Assistant <input type="checkbox"/> OB/Gyn <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Licensed Practical Nurse <input type="checkbox"/> Nurse Practitioner Was a biopsy/polypectomy performed during the endoscopy? <input type="checkbox"/> Yes <input type="checkbox"/> No Adequate bowel preparation (decided by the clinician that did endoscopy) <input type="checkbox"/> Yes <input type="checkbox"/> No Next test recommended in this cycle <input type="checkbox"/> Surgery to complete diagnosis <input type="checkbox"/> Colonoscopy <input type="checkbox"/> None, cycle complete		
Status of final diagnosis <input type="checkbox"/> Complete <input type="checkbox"/> Pending <input type="checkbox"/> Refused diagnostic follow-up <input type="checkbox"/> Lost to follow-up before final diagnosis Date of final diagnosis, refused, or lost to follow up <u>MM / DD / YYYY</u>		Final Diagnosis <input type="checkbox"/> Normal/Negative <input type="checkbox"/> Hyperplastic polyps <input type="checkbox"/> Adenomatous polyp, no high grade dysplasia <input type="checkbox"/> Adenomatous polyp, with high grade dysplasia <input type="checkbox"/> Cancer		Recurrent Cancers <input type="checkbox"/> New colorectal cancer, primary <input type="checkbox"/> Recurrent colorectal cancer <input type="checkbox"/> Non colorectal cancer primary (metastasis from another organ) <input type="checkbox"/> Unknown		
Recommended test for next cycle: <input type="checkbox"/> Take home FOB/FIT <input type="checkbox"/> Colonoscopy <input type="checkbox"/> None						
If client has a polypectomy, biopsy or surgery, complete the Colorectal Abnormal Form.						
Provider signature _____ Provider name _____						